

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032384

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4359

FILED AUG 20 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson		a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in lb 8 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Menorah Medical Center		d. STREET ADDRESS (If outside, give location) 4424 E. 63rd	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED		4. DATE OF DEATH	
First Middle Last Everett Sidney Newcomb		Month Day Year August 2 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-18-94
9. AGE (last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registrar	
11. BIRTHPLACE (City and state or country) Eden, Vermont		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME W. Sidney Newcomb		13b. MOTHER'S MAIDEN NAME Ida Smith	
14. NAME OF HUSBAND OR WIFE Madalene Rose Newcomb		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. I	
16. SOCIAL SECURITY NO. W. W. I		17. INFORMANT Madelene R. Newcomb, 4424 E. 63rd St. Kansas City, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unrecorded infection DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Kansas City, Missouri		20g. COUNTY Kansas City, Missouri	
20h. STATE Kansas City, Missouri		20i. DATE OF DEATH Aug 1 1963	
21. I attended the deceased from 1955 , to death and last saw her him alive on Aug 1 1963 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Harry Staland (Degree or title) MD	
22b. ADDRESS 751 E. G. St. K.C. Mo.		22c. DATE SIGNED 8-5-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-5-63	
23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR Stine & McClure, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 8-5-63	
26. REGISTRAR'S SIGNATURE Ruth Long			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF
Harry Staland

AUG 22 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.